Amended MDR Tracking Number: M5-04-3514-01 **(Previously M5-04-1005-01)**

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 12-08-03. Per Rule 133.308(e)(1) dates of service 12-02-02 through 12-05-02 were not timely filed.

This Amended Findings and Decision supersedes all previous Decisions rendered in this Medical Payment Dispute involving the above requestor and respondent. The Medical Review Division's Decision of 05-07-04 was appealed and subsequently withdrawn by the Medical Review Division applicable to a Notice of Withdrawal of 06-16-04 due to various reasons including but not limited to date of service 12-11-02 which was timely filed. An Order was rendered in favor of the Requestor. The Requestor appealed the Order to an Administrative Hearing.

The IRO reviewed neuromuscular shock unit, hot/cold pack therapy, electrical stimulation, ultrasound therapy, neuromuscular re-education, therapeutic activities, therapeutic exercises, electrical stimulation-unattended, unlisted modality, unlisted physician medical service, functional capacity evaluation, unlisted special service, office visit, office visit with manipulation, prolonged evaluation and management, medical conference by physician and analysis of data in computer rendered from 12-12-02 through 09-25-03 that was denied based upon "V" and "U".

The Medical Review Division has reviewed the IRO decision and determined that the requestor **did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 01-30-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

| DOS | CPT CODE | Billed | Paid | EOB Denial Code | MAR$ | Reference | Rationale |
|---|---|---|---|---|---|---|---|
| 12-11-02 | 97010-59 | $15.00 | $0.00 | D | $11.00 | Rule 133.307 (g)(3)(A-F) | Requestor billed with modifier not recognized in either 1996 or 2002 MFG, therefore no reimbursement recommended. |
| 12-17-02 | 99213-MP | $75.00 (1 unit) | $0.00 | O | $48.00 | 96 MFG E/M GR(VI)(B) | Requestor submitted documentation. Service was billed with MP modifier. Review of documentation indicates no manipulation was performed. Reimbursement not recommended. |
| 12-18-02 | 99213-MP | $75.00 (1 unit) | $0.00 | N | $48.00 | 96 MFG E/M GR(VI)(B) | Requestor did not submit relevant information to meet documentation criteria. Service was billed with MP modifier. Review of documentation indicates no manipulation was performed. Reimbursement not recommended. |
| 12-19-02 12-31-02 | 99213-MP | $150.00 (1 unit @ $75.00 X 2 DOS) | $0.00 | F | $48.00 | 96 MFG E/M GR(VI)(B) | Requestor submitted documentation. Service was billed with MP modifier. Review of documentation indicates no manipulation was performed. Reimbursement not recommended. |
| 12-11-02 through 12-19-02 (3 DOS) | 99199 | $75.00 (1 unit @ $25.00 X 3 DOS) | $0.00 | G,N | DOP | Rule 133.307 (g)(3)(A-F) | G – Not global to any other service billed on date of service, however documentation submitted by requestor does not qualify as special report which CPT code 99199 is designated for. No reimbursement recommended. |
| 12-18-02 | 97010-59 | $30.00 (2 units) | $11.00 | F, G | $11.00 | Rule 133.307 (g)(3)(A-F) | G – Not global to any other service billed on DOS, however only one reimbursement per session allowed. Requestor billed with modifier not recognized in either 1996 or 2002 MFG. Two units were billed one of which has been paid. Additional reimbursement not recommended. |

| DOS | CPT CODE | BILLED | PAID | EOB DENIAL CODE | MAR$ | Reference | Rationale |
|---|---|---|---|---|---|---|---|
| 12-11-02 12-18-02 | 97112-59 | $105.00 (1 unit @ $35.00 DOS 12-11-02 2 units @ $70.00 DOS 12-18-02 | $0.00 | F | $35.00 | Rule 133.307 (g)(3)(A-F) | Requestor billed with modifier not recognized in either 1996 or 2002 MFG, therefore no reimbursement recommended. |
| 12-19-02 | 97530 | $35.00 (1 unit) | $0.00 | F | $35.00 | Rule 133.307 (g)(3)(A-F) | Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $35.00 |
| 12-19-02 | 99361 | $53.00 (1 unit) | $0.00 | G | $53.00 | 96 MFG E/M GR (XVIII)(B) | The respondent denied the services for documentation to support the services billed. PT is not an interdisciplinary by itself therefore the documentation submitted does not support reimbursement. |
| 12-30-02 through 02-5-03 (3 DOS 4 units billed) | 99213-MP | $275.00 (1 unit @ $75.00 X 3 DOS, 1 unit @ $50.00 X 1 DOS) | $0.00 | NO EOB | $48.00 | Rule 133.304(c) | Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $48.00 X 4 units = $192.00 |
| 12-30-02 | 97010-59 | $30.00 (2 units) | $11.00 | NO EOB | $11.00 | Rule 133.304(c) | Requestor billed with modifier not recognized in either 1996 or 2002 MFG, therefore no additional reimbursement recommended. |
| 12-30-02 through 08-22-03 (11 DOS) | 99199 | $275.00 (1 unit @ $25.00 X 11 DOS) | $0.00 | NO EOB | DOP | Rule 133.304(c) | Documentation submitted by requestor does not qualify as special report which CPT code 99199 is designated for. No reimbursement recommended. |
| 12-31-02 | 97010-59 | $30.00 (2 units) | $11.00 | F | $11.00 | Rule 133.307 (g)(3)(A-F) | Requestor billed with modifier not recognized in either 1996 or 2002 MFG, therefore no additional reimbursement recommended. |
| 01-27-03 through 09-05-03 (3 DOS) | 97010-59 | $75.00 (1 unit @ $15.00 X 1 DOS and 2 units @ $30.00 X 2 DOS) | $0.00 | NO EOB | $11.00 | Rule 133.304(c) | Requestor billed with modifier not recognized in either 1996 or 2002 MFG, therefore no reimbursement is recommended. |

| DOS | CPT CODE | Billed | Paid | EOB Denial Code | MAR$ | Reference | Rationale |
|---|---|---|---|---|---|---|---|
| 1-27-03 through 3-11-03 (3 DOS) | 97032-59 | $75.00 (1 unit @ $25.00 X 3 DOS) | $0.00 | NO EOB | $22.00 | Rule 133.304(c) | Requestor billed with modifier not recognized in either 1996 or 2002 MFG, therefore no reimbursement is recommended. |
| 1-27-03 through 02-5-03 (2 DOS) | 97035-59 | $50.00 (1 unit @ $25.00 X 2 DOS) | $0.00 | NO EOB | $22.00 | Rule 133.304(c) | Requestor billed with modifier not recognized in either 1996 or 2002 MFG, therefore no reimbursement is recommended. |
| 1-27-03 through 2-5-03 (2 DOS) | 97112-59 | $140.00 (2 units @ $70.00 X 2 DOS) | $0.00 | NO EOB | $35.00 | Rule 133.304(c) | Requestor billed with modifier not recognized in either 1996 or 2002 MFG, therefore no reimbursement is recommended. |
| 2-5-03 | 97530-59 | $35.00 (1 unit) | $0.00 | NO EOB | $35.00 | Rule 133.304(c) | Requestor billed with modifier not recognized in either 1996 or 2002 MFG, therefore no reimbursement is recommended. |
| 2-21-03 | 97110-59 | $35.00 (1 unit) | $0.00 | NO EOB | $35.00 | Rule 133.304(c) | Requestor billed with modifier not recognized in either 1996 or 2002 MFG, therefore no reimbursement is recommended |
| 4-22-03 through 06-9-03 (2 DOS) | 99358 | $150.00 (1 unit @ $60.00 for 1 DOS and 1 unit @ $90.00 for 1 DOS) | $0.00 | NO EOB | $84.00 | Rule 133.304(c) | Requestor's review of the Peer Review report does not meet descriptor criteria to qualify for reimbursement nor does the review of the RME qualify for reimbursement. Reimbursement not recommended. |
| 05-1-03 | 99090 | $110.00 (1 unit) | $0.00 | G | $108.00 | 96 MFG MEDICINE GR (I)(E)(2)(a) | Per 96 MFG MEDICINE GR(1)(E)(2)(a) summary report for FCE is included in the reimbursement and separate billing is not allowed. Reimbursement not recommended. |
| 07-1-03 | 99213 | $50.00 (1 unit) | $0.00 | NO EOB | $48.00 | Rule 133.304(c) | Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $48.00 |
| 7-28-03 7-30-03 7-31-03 | 97799-CP | $3,960.00 (8 units @ $1,320.00 X 3 DOS) | $2,400.00 | NO EOB | DOP | 96 MFG GR(II)(G)(9) | Requestor submitted relevant information to support documentation criteria. Additional reimbursement recommended in the amount of $1,560.00 |

| DOS | CPT CODE | Billed | Paid | EOB Denial Code | MAR$ | Reference | Rationale |
|---|---|---|---|---|---|---|---|
| 8-18-03 through 8-22-03 (5 DOS) | 97799-CP | $6,600.00 (8 units @ $1,320.00 X 5 DOS) | $4,000.00 | NO EOB | 80% of $125.00 for non-CARF provider = $100.00 | MFG 134.202 (e)(5)(A)(ii) and E(ii) Effective 08-01-03 | Services were billed without the AP modifier indicating non-CARF program. New EOB's submitted with the Respondent's appeal letter indicates payment at $100.00 per hour therefore, reimbursement is not in dispute. |
| 9-5-03 | 97039-59 | $30.00 (1 unit) | $0.00 | NO EOB | $15.00 Medicare Fee Schedule | Rule 133.304(c) | Requestor billed with modifier not recognized in either 1996 or 2002 MFG, therefore no reimbursement is recommended |
| 9-5-03 | 99213 | $68.00 (1 unit) | $0.00 | NO EOB | $44.00 Medicare Fee Schedule | Rule 133.304(c) | Requestor did not submit relevant information to support delivery of service. No reimbursement recommended. |
| 9-15-03 | 99361 | $53.00 (1 unit) | $0.00 | NO EOB | $53.00 | Rule 133.304(c) | Requestor did not submit relevant information to support delivery of service. No reimbursement recommended. |
| 9-23-03 | 99455-WP | $300.00 (1 unit) | $0.00 | N | DOP | MFG (e)(6)(C)(D) | Requestor did not bill with the correct modifier. Per documentation submitted two units were evaluated (spine and upper extremity). No reimbursement recommended. |
| 9-23-03 | 99455-WP | $300.00 (2 units) | $0.00 | NO EOB | DOP | Rule 133.304(c) | Requestor submitted relevant information to meet documentation criteria. Reimbursement recommended in the amount of $300.00 |

| DOS | CPT CODE | Billed | Paid | EOB Denial Code | MAR$ | Reference | Rationale |
|---|---|---|---|---|---|---|---|
| 9-23-03 | 99080-69 | $20.00 | $0.00 | G,N | $15.00 | MFG(e)(6)(A) Effective 08-01-03 | Per MFG effective 08-01-03 MMI/IR includes development of the report and is global to the evaluation. No separate billing for CPT code 99080-69 is allowed. Reimbursement not recommended. |
| TOTAL | | $13,199 | $6,433.00 | | | | The requestor is entitled to additional reimbursement in the amount of $2,135.00 |

The above Amended Findings and Decision is hereby issued this 9th day of July 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

**ORDER**

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 12-19-02 through 09-23-03 in this dispute.

This Amended Order is hereby issued this 9th day of July 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh

Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M5-04-1005-01
**NEW MDR Tracking Number: M5-04-3514-01**

IRO Certificate# 5259

January 28, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___ or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY
Patient injured at work on ___ while attempting to carry heavy posts, fell backwards injuring his right shoulder, neck and lower back. Patient received extensive physical medicine treatments and underwent shoulder surgery.

REQUESTED SERVICE (S)
E0745-NU Neuromuscular shock unit, 97010-59 Hot/Cold Pack Therapy, 97032-59 Electrical Stimulation, 07035-59 Ultrasound, 97112-59 Neuromuscular Re-education, 97530-59 Therapeutic Activities, 97110-59 Therapeutic Exercises, 97014 Electrical Stimulation Unattended, 97039-59 unlisted modality, 97799-CP Unlisted Physician Medical Service, 97750-FC Functional Capacity Evaluation, 99199 Unlisted Special Service, 99213-OV, 99213-MP-OV with manipulation, prolonged evaluation, 99361 Medical Conference by Physician, 99358-52, 99090 Analysis of data in computer from dates of service 12/12/02 to 9/25/03.

DECISION
Denied.

RATIONALE/BASIS FOR DECISION
___ records fail to substantiate in any way whatsoever that the aforementioned services fulfilled the requirements of Texas Labor Code 408.021 that states:

> "a) An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that:
> (1) cures or relieves the effects naturally resulting from the compensable injury;
> (2) promotes recovery; or

(3) enhances the ability of the employee to return to or retain employment."

The records indicate the exact opposite since the patient obtained no relief from the treatments, promotion of recovery was not accomplished and there was no enhancement of the employee's ability to return to work. For documentation, you have to look no further than the provider's records. On most every visit during the time period in question, the pain rating remained constant at either 6 or 7 (out of 10) and the provider's records indicate (in the "Assessment" section) that the patient's condition had not improved. Therefore, without question, the referenced care was not indicated and was not medically necessary.